Janet T. Mills
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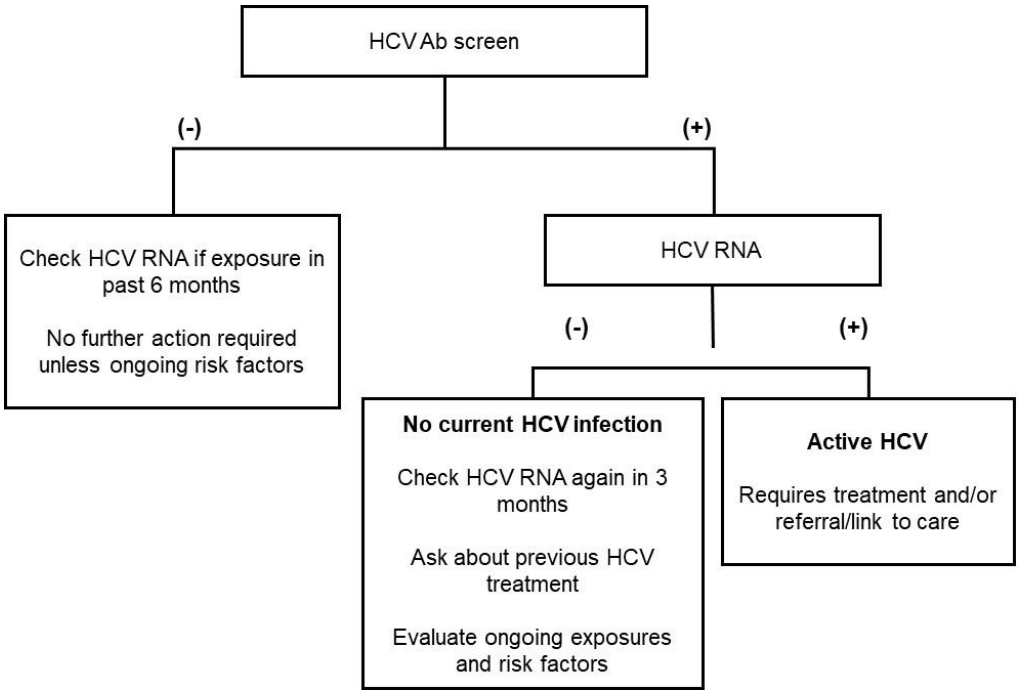
ALGORITHM FOR SCREENING AND TREATING HEPATITIS C IN PREGNANT AND POSTPARTUM WOMEN WITH SUBSTANCE USE DISORDER

All pregnant women should be screened for the Hepatitis C virus (HCV) using an antibody test (HCV Ab) at least once during pregnancy, ideally using a test that automatically detects the HCV viral load or HCV antigen (i.e., "reflexes" to HCV RNA or HCV core antigen if the antibody screen is positive). Pregnant patients with ongoing risk factors (e.g., continued substance use, risky sexual behaviors) should be re-screened if it has been more than three months since their last antibody test. Pregnant patients at risk for HCV may be at an increased risk of other infectious diseases (e.g., Hepatitis B, HIV, sexually transmitted infections) and should be monitored accordingly.



If patient is HCV +	
Pregnancy management implications	❑ Baseline liver function tests (LFTs) for comparison if concerns for preeclampsia ❑ Discuss risks of ongoing use of alcohol ❑ Screen for infectious diseases (Hepatitis B/A, sexually transmitted infections) ❑ Amniocentesis suggested over chorionic villus sampling ❑ Avoid prolonged rupture of membranes ❑ Minimize duration of fetal exposure to maternal fluids and blood ❑ Changing method of delivery *not* recommended ❑ Breastfeeding supported unless risk of blood exposure (e.g., cracked/bleeding nipples) or other contraindications (e.g., ongoing substance use, HIV +) ❑ Counsel risk of HCV vertical transmission is low (5-10%) but infant should be screened for HCV at 18 months
Consider vaccinations if risk factors present	❑ Hepatitis A, Hepatitis B, Pneumococcal
Consider assessing severity of liver disease	❑ Physical exam of the liver (normal in most patients) ❑ Routine labs (baseline LFTs as above and INR, CMP, CBC with platelet count) ❑ Refer to gastroenterology as indicated

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TREATMENT OF HEPATITIS C (HCV) IN POSTPARTUM WOMEN

Treating postpartum women for the Hepatitis C virus (HCV) reduces the risk of future maternal complications and also prevents potential vertical transmission to future children. Providing this care in obstetric clinics and substance use treatment programs increases the likelihood of HCV treatment as women are often lost to follow up in the referral process to specialty clinics. At this time, HCV treatment is not recommended for patients who are pregnant or breastfeeding. There is no requirement for stability in substance use disorder treatment (i.e., patients continuing to struggle with a substance use disorder should be offered HCV treatment). Postpartum women with HCV should be reminded that their infants should be screened at 18 months old.

The algorithm below captures the treatment protocol for patients with uncomplicated HCV. If the patient does not meet criteria for simplified treatment, the patient should be referred to a HCV specialist (typically a virologist or gastroenterologist). *These guidelines are specific to patients with Mainecare as their primary insurer and requirements may vary with other insurers.*

Step 1. Confirm the patient is eligible for simplified treatment

Any adult patient (18+) with HCV (any genotype) is eligible for **simplified** treatment who:

- ☐ Does NOT have cirrhosis by lab or clinical exam
- ☐ Has NOT been treated for HCV in the past
- ☐ Is NOT pregnant
- ☐ Is HIV and Hepatitis B surface antigen negative
- ☐ Has NO known or suspected hepatocellular carcinoma
- ☐ Has not had prior liver transplantation

Step 2. Ensure required labs have been completed

Required labs in the past 6 months include:

- ☐ FIB-4 Score: (FIB 4 = (Age x AST) / (Platelet count x √ALT)
- ☐ CBC
- ☐ Hepatic function panel including albumin, total and direct bilirubin, ALT, AST
- ☐ Calculated glomerular filtration rate: eGFR
- ☐ Quantitative HCV RNA viral load
- ☐ HCV Genotype: 1a 1b 2 3 4 5 6 mixed
- ☐ HIV antigen/antibody test
- ☐ Hepatitis B surface antigen
- ☐ Serum pregnancy test in women of childbearing age within the past 60 days

Step 3. Complete Mainecare prior authorization form #10700 (revised 6/2022)

It is critical to work with a pharmacy that can dispense and provide education about the medications used to treat HCV. The pharmacy can also assist in the evaluation of potential drug interactions with the patient's existing medications (https://www.hep-druginteractions.org/checker). Confirm that the patient has a contraceptive plan in place prior to initiating treatment of HCV and note that some contraceptives (i.e., ethinyl estradiol) may interact with certain HCV treatments. Preferred HCV simplified treatment regimens include:

- ☐ Glecaprevir/pibrentasvir (Mavyret) 100/40 mg; three (3) tablets daily for 56 days (8 weeks)
- ☐ Sofosbuvir/velpatasvir (Epclusa) 400/100 mg daily for 84 days (12 weeks)

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PROVIDER TALKING POINTS

Reassurance is critical when talking with pregnant patients about a HCV diagnosis or parents/guardians of children exposed to HCV during pregnancy.

Pregnant Patients

- Many patients may be fearful about transmitting the virus to their child. Counsel that the risk of transmission is low (5-10%) and that it does not impact their delivery or ability to breastfeed (unless other contraindications exist).
- If their child contracts HCV, it can be effectively treated even in children as young as 3 years old.
- Counsel the patient that any previous biological children, regardless of age, should also be screened for HCV as they could also have been exposed during pregnancy and it is not too late to treat.
- Encourage the patient to treat their HCV in the postpartum period (upon completion of breastfeeding, if applicable).
    - Reassure the patient that treatment is appropriate for almost everyone with HCV, even if they do not have symptoms, and that it reduces the risk of liver damage (including cancer).
    - Counsel the patient that there have been significant advancements in the treatment of HCV. Treatment consists of daily oral medication for a few months and it can effectively cure most HCV cases (over 90%) with relatively few side effects.
- Remember that it *all pregnant patients* should be screened for HCV during *each pregnancy*, regardless of risk factors.

Parents/Guardians of Children Exposed to HCV during Pregnancy

- Counsel parents/guardians that the risk of transmission during pregnancy is low (5-10%) and, if the child does contract HCV, treatment can effectively cure most HCV cases (over 90%) and can be initiated in children as young as 3 years old.
- Hepatitis C is not transmitted by casual contact and, as such, children with HCV infection do not pose a risk to other children and can participate in school, sports, and athletic activities, and engage in all other regular childhood activities without restrictions.
- Educate families and children about the risk and routes of HCV transmission, and the techniques for avoiding blood exposure, such as avoiding the sharing of toothbrushes, razors, and nail clippers, and the use of gloves and dilute bleach to clean up blood.
- Pediatric providers should screen children exposed to HCV during pregnancy for HCV (see testing algorithm). There are several screening pathways and providers may consider what is most convenient for the parents/guardians and their respective situation.
    - HCV-RNA testing at 12 months of age may be a practical strategy as children are typically already having blood drawn for lead and anemia at that visit. If HCV-RNA is not detected at 12 months of age, the child does not have HCV and no further testing is required.
    - It may be most efficient to screen for HCV at an earlier age, especially if there is concern that a child may be lost to follow up during early childhood. Providers could consider testing for HCV RNA as early as 2 months of age. If HCV RNA is not detected, the child does not have HCV and no further testing is required.
    - If HCV RNA is detected, the child should be referred to a virologist/gastroenterologist who specializes in pediatric HCV and, again, reassure parents/guardians that treatment is successful in most cases.

These recommendations are intended to enhance your care and should not replace your own clinical judgement. Questions should be directed to infectious disease, obstetric or addition medicine specialists within your health care system.

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